AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Date: ______________________

Dr. Wendy Seyller
St. Croix Vision Center
1778 Washington Ave S
Stillwater, MN 55082

Patient's Name: ______________________________

DOB: ______________________________

Detailed description of the information to be released:

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To whom my information be released: ____

If you have any questions, please call me at (651) 439-6400.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated: ______________________ Patient Signature: _____________________________________

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient: ______________________ Print Name: ______________________________

Source of Authority: ____